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May 19, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Inpatient left total knee arthroplasty

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certification: American Board of Orthopaedic Surgery
Certification in Impairment Rating Evaluations, Fourth Edition
Specializes in Lower Extremities

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Official Disability guidelines (20th annual edition & ODG treatment in Workers Compensation (13th annual edition) 2015, knee & Leg criteria has been utilized for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who injured his lower back on xx/xx/xx, when he slipped in some mud and his knee hit the running board strain on and felt the patella dislocate laterally.

On January 29, 2015, the patient was seen for left knee pain since six days. He arrived with the assistance of crutches and a knee immobilizer. The patient stated he felt like his knee cap had dislocated. He reported of history of a right total knee arthroplasty in 2010. He had been keeping a wrap on the left knee because without it, the patella would consistently dislocate laterally. Examination showed gait with crutches. The knee examination was limited secondary to guarding and pain. There was severe tenderness to the entire knee and patella with effusion 2+. The patient could not actively extend or keep his knee in extension against

the gravity and had significant pain with flexion beyond 30 degrees and was severely limited, the strength and tone was significantly decreased with moderate edema. The diagnosis was closed dislocation of the patella with possible avulsion fracture of the medial patella. The x-rays of the knee revealed laterally subluxed and tilted patella with some bony fragments medially which may be an avulsion or calcification was difficult to distinguish. There were also diffuse degenerative changes throughout the joint. noted that the patient might require a surgical intervention with the repair of the medial patellofemoral ligament complex. He was recommended magnetic resonance imaging (MRI).

On January 30, 2015, MRI of the left knee showed status post partially reduced lateral patellar dislocation, small calcified or ossified fragments adjacent to the medial patella without large intra-articular fragments, large hemarthrosis, disruption of the medial retinaculum tearing of the medial meniscus and diffuse free edge tearing throughout the lateral meniscus most pronounced in the anterior horn and body. There was no full-thickness in the cruciate ligament disruption.

On February 25, 2015, evaluated the patient for continued pain and discomfort in the left knee although it was aspirated several weeks prior. He had a significant limp. The patient had been doing exercises at home and reported some increase in his range of motion (ROM) and decreased pain. Although it was still quite severe most of the time, his knee continued to feel very unstable. The diagnosis was knee pain, contusion of the knee, closed dislocation of the patella, traumatic arthropathy of the knee, medial meniscal tear of the knee, lateral meniscal tear of the knee, loose body in the knee and degenerative joint disease (DJD) of the knee. The patient had improved pain and ROM since last visit and was able to bear some weight without using crutches. The patient was encouraged to start physical therapy (PT). He was considering moving back to Pam Springs for surgery.

On April 2, 2015, evaluated the patient for pain, swelling and knee cap maltracking. The x-rays showed end stage medial compartment and PF compartment DJD with the patella sublimated laterally. The diagnosis was osteoarthritis local lower leg, dislocation patella closed and knee DJD. recommended activity modification, exercises, electrical stimulation, weight loss, oral analgesics, cortisone injections, viscosupplementaion and surgery. The patient wished to proceed with TKA to correct the DJD and the patellar dislocation. A hinged knee brace was provided to protect the medial soft tissue repair and was recommended to limit ROM to 0-30 degrees for three weeks postoperatively would be used and a fibre wire for the medial repair. Post surgical continuous passive motion (CPM) unit was rendered beneficial to the patient and further maintain a sequential compression device (SCD) during and following surgery at home to improve the venous circulation and reduce the risk of deep vein thrombosis (DVT).

On April 7, 2015, requested authorization for left knee total arthroplasty.

On April 10, 2015, a peer review on the patient.

Per utilization review dated April 13, 2015, the request for inpatient left total knee arthroplasty was denied with the following rationale: *"Official Disability Guidelines states that individuals who are considered a reasonable candidate for total knee arthroplasty have documented evidence of severe advanced DJD that is consistent with their clinical complaints supported by exam findings and has failed to respond to all reasonable forms of conservative care. Although the records in this particular case would appear to suggest this claimant does in fact have advanced DJD of the knee, there is minimal documentation with respect to conservative care. In fact, the treating provider recommended physical therapy but it is unclear as to whether or not the claimant attended therapy. Furthermore, it is unclear whether or not this claimant has ongoing injection therapy or other forms of conservative care. As such the absence of documented evidence of lengthy course of conservative care, the request would not be considered reasonable and medically necessary."*

On April 20, 2015, appealed for left total knee arthroplasty.

Per reconsideration review dated April 24, 2015, the request for inpatient left total knee arthroplasty was denied with the following rationale: "*Per the ODG, criteria for the knee joint replacement includes conservative care: exercise therapy (supervised PT and /or homer rehab exercises) and medications (unless contraindicated: NSAID's or Visco supplementation injection or steroid injection). Additionally, the guidelines require subjective clinical findings that show limited range of motion and night time joint pain with no relief from conservative care, objective clinical findings, and age over 50 years with a body mass index of less than 40. There is no documentation in the case notes to support the patient meets the criteria for treatment with conservative care. There is no evidence to support the patient has undergone any supervised physical therapy, use of non-steroidal anti-inflammatory drugs (NSAID's), or treatment with visco supplementation or steroid injections. As such, the request is recommended for an adverse determination."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The request is to determine the need for left knee total knee arthroplasty. This case had been previously reviewed. There was insufficient information to recommend the course of treatment as being reasonable and medically necessary as there was no documentation of the extent of conservative care. Additional records appear to document the claimant has been through conservative care, including off-loading devices, bracing, and medication management.

This claimant has evidence of degenerative change. In fact, it is described as bone on bone changes in the medial and patellofemoral compartment. In review of the evidence-based Official Disability Guidelines criteria, they state that conservative care should include a home exercise program, or physical therapy as well as medical management and/or injection therapy. This claimant has used

off-loading devices as well as bracing, and physical therapy but there is no documentation of injection therapy. As such, it is unclear whether or not this claimant has truly exhausted all reasonable forms of conservative care and as such would not appear to meet reasonable evidence of based criteria.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines (20th annual edition) & ODG Treatment in Workers' Comp (13th annual edition), 2015
Knee & Leg Chapter
Knee joint replacement
ODG Indications for Surgeryä -- Knee arthroplasty:

Criteria for knee joint replacement (If only 1 compartment is affected, a unicompartmental or partial replacement may be considered. If 2 of the 3 compartments are affected, a total joint replacement is indicated.):

1. Conservative Care: Exercise therapy (supervised PT and/or home rehab exercises). AND Medications. (unless contraindicated: NSAIDs OR Visco supplementation injections OR Steroid injection). PLUS

2. Subjective Clinical Findings: Limited range of motion (<90° for TKR). AND Nighttime joint pain. AND No pain relief with conservative care (as above) AND Documentation of current functional limitations demonstrating necessity of intervention. PLUS

3. Objective Clinical Findings: Over 50 years of age AND Body Mass Index of less than 40, where increased BMI poses elevated risks for post-op complications. PLUS

4. Imaging Clinical Findings: Osteoarthritis on: Standing x-ray (documenting significant loss of chondral clear space in at least one of the three compartments, with varus or valgus deformity an indication with additional strength). OR Previous arthroscopy (documenting advanced chondral erosion or exposed bone, especially if bipolar chondral defects are noted). (Washington, 2003) (Sheng, 2004) (Saleh, 2002) (Callahan, 1995)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS). See also Skilled nursing facility LOS (SNF)